

MEDICAL HISTORY

MRN: __ _ - __ _ - __ _ - __ _ CRU ID: __ _ _ _ _ _ _	Subject ID: __ _ _ _ _ - __ _ _ _ _ _ _ _ _ _ _ Visit Date: __/__/____
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Please take the time to read and answer each question carefully by marking the response that best represents your answer.

I. Current or Past Diseases and Medical Conditions:

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
1.	Cardiovascular			
1a.	High Blood Pressure or Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1a(1) for Female)</i> <i>(If yes, skip to 1b for Male)</i>	_____ <input type="checkbox"/> Don't Know Year
1a(1).	If diagnosed with High Blood Pressure or Hypertension: For women, were you diagnosed with high blood pressure only when you were pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1b.	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1c)</i>	_____ <input type="checkbox"/> Don't Know Year
1c.	Atherosclerosis or Hardening of the Arteries <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1d)</i>	_____ <input type="checkbox"/> Don't Know Year
1d.	Cardiac Arrhythmia <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1e)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1e)</i>	_____ <input type="checkbox"/> Don't Know Year
1e.	Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1f)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1f)</i>	_____ <input type="checkbox"/> Don't Know Year
1f.	Heart Attack or Myocardial Infarction (MI) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1g)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1g)</i>	_____ <input type="checkbox"/> Don't Know Year
1g.	Coronary Artery Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1h)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1h)</i>	_____ <input type="checkbox"/> Don't Know Year

MRN: |__|_| - |__|_| - |__|_| - |__|_|

Protocol: CRU Umbrella Protocol

Form: Core Medical History 08/31/2015

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Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
1h.	Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1i)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1i)</i>	_____ <input type="checkbox"/> Don't Know Year
1i.	Poor blood flow to your legs or blocked or narrowed arteries to the legs, Claudication or Peripheral Arterial Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1j)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1j)</i>	_____ <input type="checkbox"/> Don't Know Year
1j.	Raynaud's Syndrome or Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1k)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1k)</i>	_____ <input type="checkbox"/> Don't Know Year
1k.	Blood clots in your lungs (Pulmonary Embolus) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1l)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1l)</i>	_____ <input type="checkbox"/> Don't Know Year
1l.	Blood clots in legs <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1m)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1m)</i>	_____ <input type="checkbox"/> Don't Know Year
1m.	Mini Stroke or Transient Ischemic Attack <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1n)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1n)</i>	_____ <input type="checkbox"/> Don't Know Year
1n.	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 1o)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 1n(1))</i>	_____ <input type="checkbox"/> Don't Know Year
1n(1).	If diagnosed with Stroke , please fill in type: <input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Other <input type="checkbox"/> Don't know			
1o.	Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 2a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 2a)</i>	_____ <input type="checkbox"/> Don't Know Year
2.	Diabetes and Endocrine System			
2a.	Pre-diabetes, Impaired Fasting Glucose, or Impaired Glucose Tolerance <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 2b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 2b)</i>	_____ <input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
2b.	Diabetes Type I <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 2c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 2c)</i>	_____ <input type="checkbox"/> Don't Know Year
2c.	Diabetes Type II <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 2d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 2d)</i>	_____ <input type="checkbox"/> Don't Know Year
2d.	Thyroid Disease (other than cancer) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 3a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 2d(1))</i>	_____ <input type="checkbox"/> Don't Know Year
2d(1).	If diagnosed with Thyroid Disease (other than cancer), please check all that apply: <input type="checkbox"/> Hyperthyroidism (e.g., Graves' Disease) <input type="checkbox"/> Hypothyroidism (e.g., Hashimoto's thyroiditis) <input type="checkbox"/> Enlarged Thyroid or Goiter <input type="checkbox"/> Benign Growth Nodule or Tumor			
3.	General Respiratory			
3a.	Chronic Obstructive Pulmonary Disease (COPD) (e.g. Chronic Bronchitis, Emphysema) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 3b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 3b)</i>	_____ <input type="checkbox"/> Don't Know Year
3b.	Idiopathic Pulmonary Fibrosis (IPF) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 3c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 3c)</i>	_____ <input type="checkbox"/> Don't Know Year
3c.	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 3d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 3c(1))</i>	_____ <input type="checkbox"/> Don't Know Year
3c(1).	If diagnosed with Tuberculosis, please fill in type: <input type="checkbox"/> Latent <input type="checkbox"/> Active <input type="checkbox"/> Don't know			
3d.	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 3e)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 3e)</i>	_____ <input type="checkbox"/> Don't Know Year
3e.	Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4a)</i>	_____ <input type="checkbox"/> Don't Know Year
4.	Neurological			
4a.	Seizure Disorder or Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4b)</i>	_____ <input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
4b.	Migraine Headaches (with or without Aura) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4c)</i>	_____ <input type="checkbox"/> Don't Know Year
4c.	Chronic non-migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4d)</i>	_____ <input type="checkbox"/> Don't Know Year
4d.	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4e)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4e)</i>	_____ <input type="checkbox"/> Don't Know Year
4e.	Post-Traumatic Stress Disorder (PTSD) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4f)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4f)</i>	_____ <input type="checkbox"/> Don't Know Year
4f.	Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 4g)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 4g)</i>	_____ <input type="checkbox"/> Don't Know Year
4g.	Multiple Sclerosis (MS) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 5a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 5a)</i>	_____ <input type="checkbox"/> Don't Know Year
5.	Psychological/Psychiatric			
5a.	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 5b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 5b)</i>	_____ <input type="checkbox"/> Don't Know Year
5b.	ADHD/ADD <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 5c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 5c)</i>	_____ <input type="checkbox"/> Don't Know Year
5c.	Anxiety or Panic Attack <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 5d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 5d)</i>	_____ <input type="checkbox"/> Don't Know Year
5d.	Manic-depressive Illness or Bipolar Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6a)</i>	_____ <input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
6.	Gastrointestinal			
6a.	Celiac Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6b)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6b)</i>	<input type="checkbox"/> Don't Know Year
6b.	Lactose Intolerance <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6c)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6c)</i>	<input type="checkbox"/> Don't Know Year
6c.	Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6d)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6d)</i>	<input type="checkbox"/> Don't Know Year
6d.	Ulcerative Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6e)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6e)</i>	<input type="checkbox"/> Don't Know Year
6e.	Polyps in the colon or rectum <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6f)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6f)</i>	<input type="checkbox"/> Don't Know Year
6f.	Gallbladder Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6g)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6g)</i>	<input type="checkbox"/> Don't Know Year
6g.	Stomach or Duodenal Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6h)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6h)</i>	<input type="checkbox"/> Don't Know Year
6h.	Cirrhosis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6i)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6i)</i>	<input type="checkbox"/> Don't Know Year
6i.	Fatty Liver Disease or steatosis (NASH) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6j)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6j)</i>	<input type="checkbox"/> Don't Know Year
6j.	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6k)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6j(1))</i>	<input type="checkbox"/> Don't Know Year
6j(1).	If diagnosed with Hepatitis , please check all that apply: <input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> Other <input type="checkbox"/> Don't know			
6k.	Acid Reflux (GERD) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 6l)</i>	<input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 6l)</i>	<input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
6l.	Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 7a)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 7a)	_____ <input type="checkbox"/> Don't Know Year
7.	Renal			
7a.	Chronic Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 7b)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 7b)	_____ <input type="checkbox"/> Don't Know Year
7b.	End Stage Renal Disease (ESRD) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 7c)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 7c)	_____ <input type="checkbox"/> Don't Know Year
7c.	Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 7d)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 7d)	_____ <input type="checkbox"/> Don't Know Year
7d.	Pyelonephritis, Nephritis, or Kidney Infection <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 7e)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 7e)	_____ <input type="checkbox"/> Don't Know Year
7e.	Polycystic Kidney Disease (PKD) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8a)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8a)	_____ <input type="checkbox"/> Don't Know Year
8.	Immunological			
8a.	Scleroderma or Systemic Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8b)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8b)	_____ <input type="checkbox"/> Don't Know Year
8b.	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8c)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8c)	_____ <input type="checkbox"/> Don't Know Year
8c.	Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8d)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8d)	_____ <input type="checkbox"/> Don't Know Year
8d.	Systemic Lupus Erythematosus (SLE) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8e)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8e)	_____ <input type="checkbox"/> Don't Know Year
8e.	Sjogren's (SHOW-grin) Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 8f)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 8f)	_____ <input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
8f.	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 8g)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 8g)</i>	_____ <input type="checkbox"/> Don't Know Year
8g.	Myositis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 9a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 9a)</i>	_____ <input type="checkbox"/> Don't Know Year
9.	Hematologic			
9a.	Hemochromatosis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 9b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 9b)</i>	_____ <input type="checkbox"/> Don't Know Year
9b.	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 9c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 9b(1))</i>	_____ <input type="checkbox"/> Don't Know Year
9b(1).	If diagnosed with Anemia , please check all that apply: <input type="checkbox"/> Iron deficiency anemia <input type="checkbox"/> Pernicious Anemia <input type="checkbox"/> Other <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Thalassemia			
9c.	Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 9d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 9d)</i>	_____ <input type="checkbox"/> Don't Know Year
9d.	Clotting Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 10a)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 10a)</i>	_____ <input type="checkbox"/> Don't Know Year
10.	Musculoskeletal			
10a.	Bone loss, thinning in the bones, Osteopenia, Pre-osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 10b)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 10b)</i>	_____ <input type="checkbox"/> Don't Know Year
10b.	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 10c)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 10c)</i>	_____ <input type="checkbox"/> Don't Know Year
10c.	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 10d)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 10d)</i>	_____ <input type="checkbox"/> Don't Know Year
10d.	Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 10e)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 10e)</i>	_____ <input type="checkbox"/> Don't Know Year

Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
10e.	Other type of arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 11a)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 10e(1))	_____ <input type="checkbox"/> Don't Know Year
10e(1).	If diagnosed with Other type of arthritis , specify the type of arthritis: _____			
11.	Skin			
11a.	Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 11b)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 11b)	_____ <input type="checkbox"/> Don't Know Year
11b.	Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 11c)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 11c)	_____ <input type="checkbox"/> Don't Know Year
11c.	Urticaria or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12a)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12a)	_____ <input type="checkbox"/> Don't Know Year
12.	Allergies			
12a.	Seasonal allergies <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12b)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12b)	_____ <input type="checkbox"/> Don't Know Year
12b.	Year round allergies (e.g. pets, dust, mold) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12c)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12c)	_____ <input type="checkbox"/> Don't Know Year
12c.	Food allergies <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12d)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12d)	_____ <input type="checkbox"/> Don't Know Year
12d.	Hayfever (runny nose) <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12e)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12e)	_____ <input type="checkbox"/> Don't Know Year
12e.	Drug allergies <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12f)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12e(1))	_____ <input type="checkbox"/> Don't Know Year
12e(1).	If diagnosed with Drug allergies , specify the type of drug/reaction: _____			
12f.	Other allergies or allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to 12g)	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, skip to 12f(1))	_____ <input type="checkbox"/> Don't Know Year

12f(1).	If diagnosed with other allergies or allergic reactions , specify the type of allergy/reaction: _____			
Item	Has a doctor or other health care provider ever told you that you have:	If Yes, when? (YYYY)	Is it ongoing?	If No, when was it resolved? (YYYY)
12g.	Any other allergies or allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 13)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 12g(1))</i>	_____ <input type="checkbox"/> Don't Know Year
12g(1).	If diagnosed with any other allergies or allergic reactions , specify the type of allergy/reaction: _____			
13.	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 15)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 13a)</i>	_____ <input type="checkbox"/> Don't Know Year
13a.	If diagnosed with Cancer, specify the type of cancer: _____			
13b.	Have you ever received chemotherapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
13c.	Have you ever received radiation therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Any Other Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 15)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 14a)</i>	_____ <input type="checkbox"/> Don't Know Year
14a.	If diagnosed with Any Other Cancer , specify the type of cancer: _____			
15.	Other condition not listed above <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 17a for Female)</i> <i>(If no, skip to 18a for Male)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 15a)</i>	_____ <input type="checkbox"/> Don't Know Year
15a.	If diagnosed with Other condition not listed above, specify the condition: _____			
16.	Any other condition not listed above <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to 17a for Female)</i> <i>(If no, skip to 18a for Male)</i>	_____ <input type="checkbox"/> Don't Know Year	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, skip to 16a)</i>	_____ <input type="checkbox"/> Don't Know Year
16a.	If diagnosed with any other condition not listed above, specify the condition: _____			

Item	Question	Answer
17.	For Women Only (Men skip to question 18)	
17a.	At what age did your menstrual periods begin?	<div style="text-align: center;">_ _ _</div> <input type="checkbox"/> Don't Know
17b.	If pre-menopausal, are your menstrual cycles regular (with the exception of pregnancy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17c.	Have you been treated for infertility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17d.	Have you had a hysterectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17e.	Have you started or gone through menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17f.	Are you currently taking birth control pills or other hormonal contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken birth control pills or other hormonal contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17g.	Are you currently taking hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17h.	Has a doctor or other health care provider ever told you that you have Endometriosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17i.	Has a doctor or other health care provider ever told you that you have fibroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	For Men Only (Women skip to question 19) Has a doctor or other health care provider ever told you that you have:	
18a.	Enlarged prostate or benign prostatic hyperplasia (BPH)	<input type="checkbox"/> Yes <input type="checkbox"/> No
18b.	Inflammation of the prostate or prostatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Family History Has any blood relative (children, parents, siblings) had:	
19a.	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No

19b.	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
19c.	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
19d.	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
19e.	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
19f.	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
19g.	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
19h.	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
19i.	Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
19j.	Reproductive System Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
19k.	Mental Retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No
19l.	Congenital Malformation (Birth Defect)	<input type="checkbox"/> Yes <input type="checkbox"/> No

II. Smoking History:

Item	Question	Answer
1.	In your lifetime have you smoked at least 100 cigarettes? <i>(If no, skip to 3)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
1a.	Do you currently smoke cigarettes? <i>(If no, skip to 2a)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b.	How many cigarettes do you smoke per day on average?	<p>— —</p> <p>CIGARETTES PER DAY</p> <input type="checkbox"/> Don't Know
1c.	How many years have you smoked cigarettes? If you are a current smoker, please skip to question 3.	<p>— —</p> <p>YEARS</p> <input type="checkbox"/> Don't Know
2.	When you did smoke:	
2a.	How many cigarettes did you smoke per day on average?	<p>— —</p> <p>CIGARETTES PER DAY</p> <input type="checkbox"/> Don't Know
2b.	How many years did you smoke cigarettes?	<p>— —</p> <p>YEARS</p> <input type="checkbox"/> Don't Know
2c.	What year did you quit smoking cigarettes?	<p>— — — —</p> <p>YYYY</p> <input type="checkbox"/> Don't Know
3.	Have you ever smoked cigars, pipes, kreteks, or other tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you smoke cartridge –based electronic cigarettes? <i>(e.g. Blu and V2 cigs) (If no, skip to 5)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a.	How many cartridges/refills do you use per day on average?	<p>— —</p> <p>CARTRIDGES PER DAY</p> <input type="checkbox"/> Don't Know
5.	Do you smoke liquid refill-based electronic cigarettes? <i>(If no, skip to 7)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5a.	What is the nicotine concentration?	<p>— — %</p> <input type="checkbox"/> Don't Know

6.	How many years have you smoked electronic cigarettes?	<p>— — YEARS</p> <input type="checkbox"/> Don't Know
7.	Have you ever used smokeless tobacco products (chewing tobacco or snuff)? <i>(If no, skip to 9)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7a.	Do you currently use smokeless tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7b.	How many times per day on average?	<p>— — TIMES PER DAY</p> <input type="checkbox"/> Don't Know
7c.	How many years have you used these products?	<p>— — YEARS</p> <input type="checkbox"/> Don't Know
8.	When you did use smokeless tobacco products:	
8a.	How many times per day on average?	<p>— — TIMES PER DAY</p> <input type="checkbox"/> Don't Know
8b.	How many years did you use these products?	<p>— — YEARS</p> <input type="checkbox"/> Don't Know
8c.	What year did you quit?	<p>— — — — YYYY</p> <input type="checkbox"/> Don't Know
9.	Do you ever have exposure to tobacco smoke in an indoor workspace?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Not counting yourself, how many people currently living in your home smoke regularly indoors?	<p>— — PEOPLE</p> <input type="checkbox"/> Don't Know

III. Alcohol History:

Item	Question	Answer
1.	In your entire life, have you had at least 1 drink of any kind of alcohol, not counting small tastes or sips? <i>(If no, skip to Section IV, 1)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	During the past month, have you had at least one alcoholic drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	How many glasses of wine do you usually have per week? <i>(If less than 1 per week, enter 00)</i>	— — DRINKS PER WEEK <input type="checkbox"/> Don't Know
4.	How many cans, bottles, or glasses of beer do you usually have per week? <i>(If less than 1 per week, enter 00)</i>	— — DRINKS PER WEEK <input type="checkbox"/> Don't Know
5.	How many drinks of liquor, spirits, or mixed drinks do you usually have per week? Spirits include liquors such as whiskey, vodka, tequila, rum, and mixed drinks such as martinis (1 serving = 1.5 oz or 1 shot) <i>(if less than 1 per week, enter 00)</i>	— — DRINKS PER WEEK <input type="checkbox"/> Don't Know
6.	How many years have you drank alcohol regularly?	— — YEARS <input type="checkbox"/> Don't Know

IV. Sleep:

Item	Question	Answer
1.	Have you been told by a doctor or other health care provider that you have chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	How many hours of sleep do you usually get per night?	— — HOURS PER NIGHT <input type="checkbox"/> Don't Know
3.	How many nights per week do you typically have trouble sleeping?	— — NIGHTS PER WEEK <input type="checkbox"/> Don't Know

V. Surgical History:

Have you undergone any surgeries? Yes No
(If no, skip the rest of the questions)

If yes, please provide the name of the surgery along with the year. If the surgery occurred more than once, please list each surgery along with the year.

Item	Surgery	Date (YYYY)
1.		_____ <input type="checkbox"/> Don't Know
2.		_____ <input type="checkbox"/> Don't Know
3.		_____ <input type="checkbox"/> Don't Know
4.		_____ <input type="checkbox"/> Don't Know
5.		_____ <input type="checkbox"/> Don't Know
6.		_____ <input type="checkbox"/> Don't Know
7.		_____ <input type="checkbox"/> Don't Know
8.		_____ <input type="checkbox"/> Don't Know
9.		_____ <input type="checkbox"/> Don't Know
10.		_____ <input type="checkbox"/> Don't Know

THANK YOU FOR COMPLETING THE MEDICAL HISTORY SURVEY!

FOR OFFICE USE

MEDICAL, PROCEDURE AND MEDICATION HISTORY REVIEWED BY _____

DATE (MM/DD/YYYY): ___/___/_____